State of Rhode Island & Providence Plantations
Office of Employee Benefits
One Capitol Hill
Providence, RI 02908-5860
Office: (401) 222-3160
Fax: (401) 222-6391

STATE OF RHODE ISLAND GROUP HEALTH PLAN
Domestic Partner Dependent Declaration Form

You must complete this form and return it to the Office of Employee Benefits to be eligible for favorable tax treatment. If you have any questions, please call your agency human resources department or the Office of Employee Benefits.

If your domestic partner does not meet the definition of a dependent pursuant to Internal Revenue Code Section 152 (as revised by 105(b)), federal law requires that the fair market value of the coverage extended to your domestic partner will be imputed to you as income on your paycheck and will be reflected on the W-2 issued to you by the State of Rhode Island.

Name of Participant (Employee): _____
(Print full name)

Name of Domestic Partner: _____
(Print full name)

SECTION 1.

(a) My domestic partner lives with me and is a member of my household.
_____Yes _____No

(b) My domestic partner receives over one-half of his or her support from me.
_____Yes _____No

(c) My domestic partner cannot be claimed as a "qualifying child" by anyone else. (Generally, a qualifying child is a dependent under age 19 (age 24 if a full-time student) that meets certain requirements).
_____Yes _____No

(d) My domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico at some time during the calendar year in which I am claiming him or her as a dependent.
_____ Yes _____No

If you have answered "Yes" to <u>all</u> of the questions in Section 1, complete Section 2.

If you have answered "No" to any question in Section 1, complete Section 3.

SECTION 2. CERTIFICATION – Meets IRS Requirements

I, _____, hereby certify that I have answered the applicable questions truthfully and certify to the Plan Administrator that my domestic partner does meet the definition of a dependent pursuant to Section 152 (as revised by 105(b)) of the Internal Revenue Code.

_____ _____

Date Plan Participant (Employee)

SECTION 3. CERTIFICATION – Does Not Meet IRS Requirements

I, _____, hereby certify that I have answered the applicable questions truthfully and certify to the Plan Administrator that my domestic partner does not meet the definition of a dependent pursuant to Section 152 (as revised by 105(b)) of the Internal Revenue Code.

Since your domestic partner does not meet the definition of a dependent pursuant to Internal Revenue Code Section 152 (as revised by 105(b)), the fair market value of the coverage extended to your domestic partner will be imputed to you as income on your paycheck and will be reflected on the W-2 issued to you by the State of Rhode Island.

_____ _____

Date Plan Participant (Employee)

YOU SHOULD KEEP A COPY OF THIS CERTIFICATION WITH YOUR BENEFITS INFORMATION AND RETURN THE ORIGINAL COMPLETED FORM TO THE OFFICE OF EMPLOYEE BENEFITS.

THIS DECLARATION FORM SHALL REMAIN ON FILE AND WILL APPLY IN SUBSEQUENT YEARS – UNLESS YOU FILE A NEW DECLARATION FORM. YOU WILL HAVE AN OPPORTUNITY TO COMPLETE A NEW DECLARATION FORM DURING EACH OPEN ENROLLMENT PERIOD.

IN THE EVENT THAT THERE IS A CHANGE IN THE FUTURE WHICH WOULD AFFECT AN ANSWER TO A QUESTION ON THIS FORM, SUCH AS A CHANGE IN SUPPORT (i.e., my dependent domestic partner no longer receives over one-half of his/her support from me), YOU ARE REQUIRED TO INFORM THE OFFICE OF EMPLOYEE BENEFITS IN WRITING AS SOON AS PRACTICABLE.